

Michigan Department of Community Health Division of Health, Wellness and Disease Control

Strategic Plan Fiscal Years 2011-2015

INTRODUCTION

This strategic plan provides a blueprint and clear priorities to guide the work of the Division of Health, Wellness and Disease Control (DHWDC) of the Michigan Department of Community Health (MDCH) over a five-year period covering fiscal years 2011 through 2015. It was developed with the active involvement of the entire Division and the advice and input of stakeholders including other MDCH bureau and division directors, representatives of local health departments, and program experts from outside the State.

Before developing the plan, the Division commissioned an extensive environmental scan that obtained input from nearly 400 internal and external stakeholders from groups such as people living with HIV/AIDS (PLWH), local health departments, HIV case managers, Michigan HIV/AIDS Council members and advisors, substance abuse treatment program directors, senior managers from other MDCH components, and other public health personnel involved in STD, HIV, and health disparities/minority health activities. The scan was implemented by a team from Mosaica: The Center for Nonprofit Development and Pluralism, a nonprofit organization with extensive experience with HIV/AIDS, public health, and minority health issues.

The entire process was implemented with the guidance of a Working Group of Division staff and stakeholders, the Division Director, and the strategic planning Project Officer.

Contents of the Plan: The plan states the Division's *vision, mission, values*, major five-year *goals, objectives*, and key *indicators* that measure progress towards those goals.

- The *vision* describes the ideal community DHWDC is working towards – what it wants Michigan to look like in the future.
- The *mission* is the stated purpose for the Division’s existence – its public promise of what it will contribute towards reaching the vision.
- *Values* are the beliefs or principles the Division holds dear – the internal guidelines for its actions and decisions. Values are held tightly and are not changed or swayed by external forces.
- Each *goal* in the plan states a desired long-term impact of Division programs or activities, which may take a long time and multiple programs or activities to achieve. Each goal has *objectives* and *indicators*.
- An *objective* states a near-term or intermediate accomplishment that contributes to the attainment of the goal. Objectives include *indicators* that are specific, measurable, and reasonable, and include a time deadline (one year, a specific date, or the end of the five-year period covered by the strategic plan). An indicator should measure either a health-related outcome or a system or process that helps demonstrate that the objective is being met. For each *indicator*, the Division will establish baseline data describing status as of the beginning of the five-year plan or – where new data collection is required, by the end of the first year of the plan – and will collect comparable data to measure progress over time, generally annually.
- A *strategy* is a broad approach to be used in working towards goals and objectives. It typically includes a variety of different types of activities or tactics.

Health Equity Concepts: Understanding the Division’s strategic plan and the *Michigan Health Equity Roadmap* will be enhanced by a shared understanding of the following key concepts, with an emphasis on racial and ethnic minorities:

- ***Health disparities*** are significant differences in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in a racial or ethnic minority population as compared to the health status of the general population. Health disparities refer to measured health differences between two populations, regardless of the underlying reasons for the differences.
- ***Health inequities*** are differences in health across population groups that are systemic, unnecessary, and avoidable, and are therefore considered

unfair and unjust. Health inequities have their roots in unequal access or exposure to social determinants of health (SDOH) such as education, healthcare, and healthy living and working conditions. Racial and ethnic minority populations are disproportionately impacted by poor conditions in these areas which, in turn, result in poor health status and health outcomes.

- ***Health inequalities*** have been used interchangeably with both *health disparities* and *health inequities*. In the *Michigan Health Equity Roadmap*, the term *health inequalities* is used distinctly to connote health differences related to unfair and unjust social contexts (i.e., inequities) rather than simple observations of difference in health determinants or health outcomes noted between populations (i.e., disparities).
- ***Health equity*** is the absence of systematic disparities in health and its determinants between groups of people at different levels of social advantage. Health equity falls under the umbrella of social justice, which refers to equitable allocation of resources in society. To attain health equity means to close the gap in health between populations that have different levels of wealth, power, and/or social prestige. For example, low-income persons and racial/ethnic minorities generally have poor health relative to people who have more economic resources or who are members of more powerful and privileged racial groups. Eliminating health disparities and health inequities between racial and ethnic populations moves us toward our goal of health equity, and a significant focus of this effort is to address the social determinants of health that influence our priority public health outcomes.
- ***Social determinants of health*** refer to social, economic, and environmental factors that contribute to the overall health of individuals and communities. *Social factors* include racial and ethnic discrimination, political influence, and social connectedness. *Economic factors* include income, education, employment, and wealth. *Environmental factors* include living and working conditions, transportation, and air and water quality. A focus on health equity in Michigan calls for more targeted efforts to address these and other social determinants of health in order to optimize health promotion and disease prevention efforts.

THE PLAN

Vision

Michigan will be a state where health equity is a core focus in prevention, care, and treatment for all residents and:

- New HIV/AIDS, hepatitis C, and STD infections have been eliminated
- Residents receive culturally appropriate, quality prevention, care/treatment, and support services
- Discrimination, stigma, homophobia, and racism have been eliminated
- Health disparities for racial/ethnic and sexual minorities have been eliminated

Mission

To provide leadership that works to assure health equity for all people in Michigan with a focus on:

- Eliminating health disparities for racial, ethnic, and sexual minority populations
- HIV/STD/hepatitis C care and prevention

Values

The Division of Health, Wellness and Disease Control is committed to:

- **Integrity**, including honesty, ethical behavior, accountability, and transparency regarding our programs and our decisions
- **Quality and professionalism** in all our activities
- **Community engagement** of all cultural and ethnic populations to inform program and policy
- **Diversity, equity, and inclusion**, internally and externally
- **Leadership, commitment, and excellence**, recognizing that we lead by serving our clients and community

PROGRAMMATIC GOALS AND KEY INDICATORS OF PROGRESS AND SUCCESS

The Division has identified three major program goals to guide its work over the next five years, as well as selected objectives and indicators used for measuring or assessing progress towards achieving these goals. The Division will use these goals to inform the development of annual work plans, including projected outputs and interim objectives. Unless otherwise indicated, the baseline for progress measurement is Fiscal Year 2010.

Goal #1: To reduce the burden of STDs including HIV and hepatitis C by facilitating and providing high quality prevention, care, and disease intervention services that address social determinants of health.

Meeting this goal requires increased availability and access to testing, increased targeting of resources to the most impacted populations, integration of services, quality improvement in the delivery of services, and decreased incidence of disease.

Objective:

A. By 2015, decrease the number of new STD, HIV, and hepatitis C infections.

Indicators:

1. Decrease by 5% the incidence of STDs, HIV, and hepatitis C among racial, ethnic, and sexual minorities.
2. Increase by 10% the number of tests for hepatitis C conducted for at-risk individuals in publicly-supported HIV testing sites and Federally Qualified Health Centers (FQHCs).
3. Increase to 85% the proportion of clients diagnosed with early syphilis who are treated within 14 days from date of specimen collection.
4. Increase to 90% the proportion of clients diagnosed with gonorrhea and chlamydia in publicly-supported STD and family planning clinics who are treated within 30 days from date of specimen collection.

5. Increase from 88% to 90% the number of HIV positive persons who are tested in publicly-supported sites who learn their HIV test results.
6. Increase from 65% to 80% the number of individuals newly diagnosed with HIV who are successfully linked to care and treatment for HIV disease within three months of diagnosis.
7. Increase by 20% the number of sex and/or needle-sharing partners of individuals with HIV and syphilis who receive partner services.
8. Increase by 15% the number of HIV and syphilis sex and/or needle-sharing partners who learn their own syphilis or HIV status.
9. Increase by 10% the number of people living with HIV/AIDS who are tested for hepatitis C in publicly-supported care and treatment sites.
10. Increase by 10 percentage points the number of individuals ages 18-64 who know their HIV status, as measured by the Behavioral Risk Factor Surveillance System.*

Objective:

- B. By 2015, increase targeting in publicly-supported HIV and STD prevention, testing, and treatment sites to the populations most affected by these diseases.

Indicators:

1. Increase by 15% the number of people tested for HIV and STDs in publicly-supported sites who are from priority racial, ethnic, and sexual minority populations, consistent with epidemiologic data.
2. Increase by 30% the number of HIV-infected clients reported in CAREWare that are tested at recommended intervals for STDs (baseline to be established by 2011).
3. Increase by 20% the number of people diagnosed with an STD that know their HIV status.

* The Behavioral Risk Factor Surveillance System uses random telephone sampling to determine the number/proportion of people who know whether they are HIV-positive or -negative.

4. Increase by 30% the number of people with HIV in publicly-supported care and treatment sites that are tested for hepatitis C.
5. Increase by 15% the number of sexual minorities with HIV who participate in prevention interventions.

Objective:

C. By 2015, improve the quality of HIV/AIDS, STD, and hepatitis C-related services funded by the Division.

Indicators:

1. Provide integrated HIV, STD, and hepatitis C prevention, testing, and care services to at-risk and co-infected populations.
2. Increase by 10% the number of private laboratories reporting complete STD testing data.
3. Increase by 40% the collection and documentation of the five HIV quality indicators required by the Division.
4. Increase by 25% the quality of care for HIV-positive individuals based on the five quality indicators collected by the Division.
5. Increase to 65% the proportion of the total chlamydia tests provided in publicly supported venues that are individuals aged 15-24.

Goal #2: To facilitate systems change necessary to improve the health status of impacted communities, with emphasis on racial and ethnic (African Americans, Hispanics/Latinos, Asian Americans/Pacific Islanders, Native Americans/American Indians, and Arab Americans/Chaldeans) and sexual minorities.

Achieving health equity underlies all public health work and can be achieved only through coordinated efforts, increased knowledge and capacity, targeted resources, and strengthened collaborations. The Division will work in collaboration with internal and external partners to enhance capacity and commitment to reach this goal.

Objective:

A. By 2015, improve access to equitable, quality health care.

Indicators:

1. Increase by 25% the number of internal and/or external partners and collaborators working to improve access to equitable, quality health care.
2. Increase by 15% the percent of racial and ethnic minorities who report having had a routine check-up within the past year.
3. Increase by 15% the percent of racial and ethnic minorities who have a personal health care provider.
4. Increase by 15% the percent of racial and ethnic minorities who report having health care access within the past 12 months.
5. Decrease by 15% the percent of racial and ethnic minorities who report cost as a barrier to accessing health care in the past 12 months.

Objective:

B. By 2015, expand the network of core service providers in areas of high unmet need.

Indicators:

1. Increase by 20% the number of FQHCs that provide prevention, primary care, and treatment for people with HIV.
2. Increase by 10% the number of primary and specialty care providers that provide care and treatment for people with HIV, STDs, and hepatitis C.
3. Increase by 20% the number of substance abuse and/or mental health providers within the Division network that serve people with HIV.

Objective:

C. By 2015, increase organizational capacity and engagement, of internal and external partners, to address health equity.

Indicators:

1. Increase by 25% the number of Division partners and organizations that can demonstrate increased capacity to address health inequalities (baseline to be determined by May 2011).
2. Increase by 25% the amount of total funding to the Department, Division, and external partners used to address health inequalities and health disparities (baseline to be determined by May 2011).
3. Increase by 25% the number of Department, Division, and external partner activities designed to increase knowledge, build skills, or establish policies/programs related to social determinants of health, health equity, and social justice among government, healthcare, community-based organizations, and other stakeholders.
4. Increase by 25% the number of Department, Division, and external partner activities designed to increase knowledge, build skills, or establish policies/programs related to Culturally and Linguistically Appropriate Services (CLAS) Standards among government, healthcare, community-based organizations, and other stakeholders.
5. Increase by 20% the number of internal programs and external organizations using health equity assessment tools and/or adopting the use of CLAS and other cultural competency standards, as measured by the annual health disparities survey and other periodic surveys and interviews (baseline to be determined by May 2011).
6. Increase by 20% the proportion of federal and state resources allocated within the state in areas of highest unmet need for HIV-related primary medical care for priority racial/ethnic populations and sexual minorities.

Objective:

- D. By 2015, promote the reduction of stigma and discrimination against people living with HIV, STD, hepatitis C, racial/ethnic minority populations, sexual minorities, and injection drug users.

Indicator:

1. Increase by 25% the number of community partners who provide services that reduce stigma and discrimination (baseline to be determined by May 2011).

Objective:

- E. By 2015, increase the collection of race, ethnicity, preferred language, and health status data on the five mandated racial and ethnic populations by internal programs and external partner organizations.

Indicators:

1. Increase by 25% the percent of collaborating entities that collect race, ethnicity, and preferred language data on the five mandated racial and ethnic populations (baseline to be determined by May 2011).
2. Increase by 25% the percent of agencies that adhere to Office of Minority Health, MDCH standards for collection of racial, ethnic, and preferred language data (baseline to be determined by May 2011).
3. Increase by 10% the number of agencies that utilize health equity indicators for the five racial and ethnic minority populations (baseline to be determined by December 2011).
4. Increase by 20% the completeness of case report forms (race, ethnicity, and sex of sex partner data) for all reported STD cases from publicly supported sites, to better target resources to the most impacted populations.

Goal #3: To work to assure that the care and prevention needs of racial, ethnic, and sexual minorities are met in a rapidly changing environment, with emphasis on HIV, STDs, and hepatitis C.

Regardless of changes in the health care system as a result of budget constraints, health care reform, and other factors, the Division will work to assure that core public health functions continue without reduction or

interruption, and that there is a continuing focus on reducing health disparities.

Objective:

A. By 2015, decrease the level of unmet need for HIV-related primary medical care.

Indicators:

1. Increase by 20% the number of people with HIV who are linked to medical care and supportive services.
2. Increase by 5% the number of PLWH that remain in medical care.
3. Increase by 20%, in each Metropolitan Statistical Area, the number of people who remain in medical care.
4. Increase by 5% the number of pregnant women being routinely tested for HIV and syphilis during pregnancy.

Objective:

B. By 2015, develop a mechanism for obtaining information on, and responding to, changes in the health care environment.

Indicators:

1. By May 2011, establish a work group that meets quarterly to develop a work plan that focuses on HIV, STD, hepatitis C, minority health, and health disparities reduction to assure transition and integration of services during implementation of health care reform.
2. By December 2011, develop a work plan that will address service quality and health disparities reduction efforts for racial, ethnic, and sexual minority populations.

Objective:

C. By December 2011, establish a comprehensive sexual health framework that guides the Division in promoting a holistic approach to disease prevention.

Indicators:

1. By March 2011, establish a work group that includes representation from HIV, STD, hepatitis C, Health Disparities Reduction/Minority Health, Adolescent Health, Department of Education, and select others representing entities whose work is related to sexual health.
2. By December 2011, develop guidance that addresses integration of messaging, service, and referral mechanisms that fosters comprehensive sexual health.

STRATEGIES

The Division will achieve its goals through the use of interrelated strategies described below and reflected in annual work plans for the Division's sections and units.

Strategy #1: Education, Monitoring, and Advocacy – The Division will maintain a pro-active role as partner, educator, information source, monitor, and advocate for its target populations and stakeholders regarding changes in the environment and their implications for service delivery.

Strategy #2: Restructuring/Integration – The Division will restructure to integrate services and maximize program efficiency and effectiveness.

Strategy #3: Relationship Building – The Division will create and strengthen relationships and networks with individuals and programs across MDCH and with external stakeholders to better understand and meet community needs and maximize resources and expertise.

Strategy #4: Capacity Building – The Division will provide information, training, and technical assistance to enhance its capacity and that of its partners and stakeholders.

Strategy #5: Communication – The Division will emphasize vertical and horizontal communication among staff within and across units and sections, as well as frequent information sharing and communications with providers, other partners, and the public.

Strategy #6: Evaluation and Continuous Quality Improvement (CQI) – The Division will expand its capacity for data-driven decision making by enhancing processes and capacity for data gathering, analysis, monitoring, CQI and quality management, and other evaluation.

Strategy #7: Use of Technology – The Division will enhance its efficiency and program effectiveness by increasing technological capacity and use of technology. This includes enhancing staff access and skills for implementing use of new technologies.

Strategy #8: Resource Expansion – In order to meet program goals and strengthen internal operations, the Division will work to obtain adequate resources, including funding, expertise, leverage, and collaboration. The management team leads resource expansion efforts, but all staff have roles to play.

Strategy #9: Internal Environment and Operations – The Division will work to strengthen internal operations.

IMPLEMENTATION, MONITORING, AND EVALUATION OF PROGRESS

This plan provides a blueprint for the Division to develop annual work plans within and across units and monitor progress towards stated goals. As a living document, the plan will be reviewed at least annually and refined as needed.

Implementation will be a shared responsibility of all staff, with specific individuals and multi-unit groups taking the lead on particular goals and strategies. Each unit will collect data to measure success and review progress on plan goals and strategies monthly at the unit level. Cross-unit discussion of shared goals will occur at least quarterly, as will Division-level meetings to review progress.

A Futures Group composed of staff from all units and levels will take responsibility for monitoring and recommending refinement and refining the strategic plan. This group will include the Working Group that helped develop this strategic plan as well as management staff. It will:

1. Review annual work plans to assure that they address key goals and strategies in the plan.
2. Specify collection of baseline and progress data.
3. Work with staff to support and assure that baseline and progress data on key indicators are obtained and reviewed to monitor progress towards plan goals.
4. Assure that all staff as well as Division stakeholders receive an annual written summary report providing feedback on strategic plan progress and challenges.
5. Obtain regular input on external events and factors that need to be addressed by the Division and assess their implications for the Division and its stakeholders.
6. Recommend changes in plan strategies or indicators as appropriate, based on this review.